Analyzing Trade-offs and Making Decisions

A Staffing and Workload Webinar

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October 30, 2019

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- **Upcoming Webinars:**
  - **Advancing the Field of Pediatric Palliative Care**

  Friday, November 6 at 11:00am ET
  - **An Interdisciplinary Panel Discussion about Staff Changes and Workload Management (A Staffing and Workload Webinar)**

  Thursday, December 12 at 12:30pm ET

- **Virtual Office Hours:**
  - **Improving Team Effectiveness**

  Thursday, October 31 at 2:00pm ET
  - **Measurement for Community Palliative Care**

  Tuesday, November 5 at 2:00pm ET

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Learning Objectives

- Identify principles that can help programs achieve growth goals and secure associated resources
- Describe four factors that can impact staffing and workload planning across settings
- Understand how to analyze staffing and workload trade-off decisions

Survey

➔ *Based on your experience, what have been the biggest factors that have impacted staff you needed and how many patients your team could see? (select up to 3)*

- ❑ Mix and complexity of patients
- ❑ Geography (e.g. location of ICU, driving distance)
- ❑ Team composition (do you have a triage role?)
- ❑ Skill and experience of team
- ❑ Role of palliative care service (co-management, consult only)
- ❑ Presence of learners
- ❑ Budget (driving what you have available to work with)
- ❑ wRVU targets / expectations

Common Questions…

- What are wRVU's (worked Relative Value Unit) and how do they relate to productivity targets for my team?
- How many consults should an MD, APP, or any team member see each year?
- What is the right staffing model?
- And given palliative care is a team sport…how many patients can a **team** care for?

The Answer…

“It depends…”

- Staffing mix - do you have an RN coordinator, dedicated social worker, etc.
- Size and complexity of the organization - large hospital, multiple sites, home
- Integrated or not
- Setting and geography – travel time
- Learners
- Others….

Interdependent Variables Impact Program Design, Staffing, and Volume

Plus organizational factors such as:
- ✓ Organizational home
- ✓ Degree of integration into hospital, system, etc.

- Patient Conditions & Mix
- Referring Source Demographics
- Payer Mix
- Geography

- MD:APP Mix
- Interdisciplinary Team (Social Worker, Chaplain)
- RN Coordinator
- Team Norms

- Weekend Coverage
- Time to Consult
- Consult Only and/or Co-management Service
- 24/7 Access

TIP: *It is important to match service promises with staffing.*

Fundamental Strategies to Consider When Making Staffing and Workload Decisions and Trade-Offs

1: Establishment of Organizational Culture and Mission

Clarify the purpose and scope of the program	• You can get pulled in many directions – set boundaries
Define the role of each setting	• Who are you serving in the clinic or home and why are you there?
Partners and stakeholders	• Can you partner and share resources? • What do your referring partners need from you?
Bottom Line	• There are limited resources - work with what you have • Are you demonstrating impact and value to your funders?

2: Understand Challenges to and Plan for Stable Staffing

Limited workforce	• Assess and develop the skills of the staff you have • Be creative and thoughtful about recruitment
Workload distribution	• Establish ranges for workload (e.g. 2-4 new consults) • Monitor individual/team thresholds day-to-day
Isolation & burnout	• Maintain connections to the team and communicate • Consider risks of 100% clinical time expectations
Retirements & planned transitions	• Start planning now for a known transition • Expect some % of turnover

3: Assess Volume and Staffing via Strategy (revisiting Needs Assessment)

Changing priorities	• Has there been a growth or reduction in referrals from one disease type or referral source? Why?
Changing partners	• Are there new community-based services? • Is there a new group practice or hospital?
Altering target population and corresponding resource allocation	• Do you need a team for a new geography or unit? • Does your team have the skills needed?

TIP: *Continuously work to understand what stakeholders need.*

4: Continuously Assess the Team to Optimize Skills and Strengths

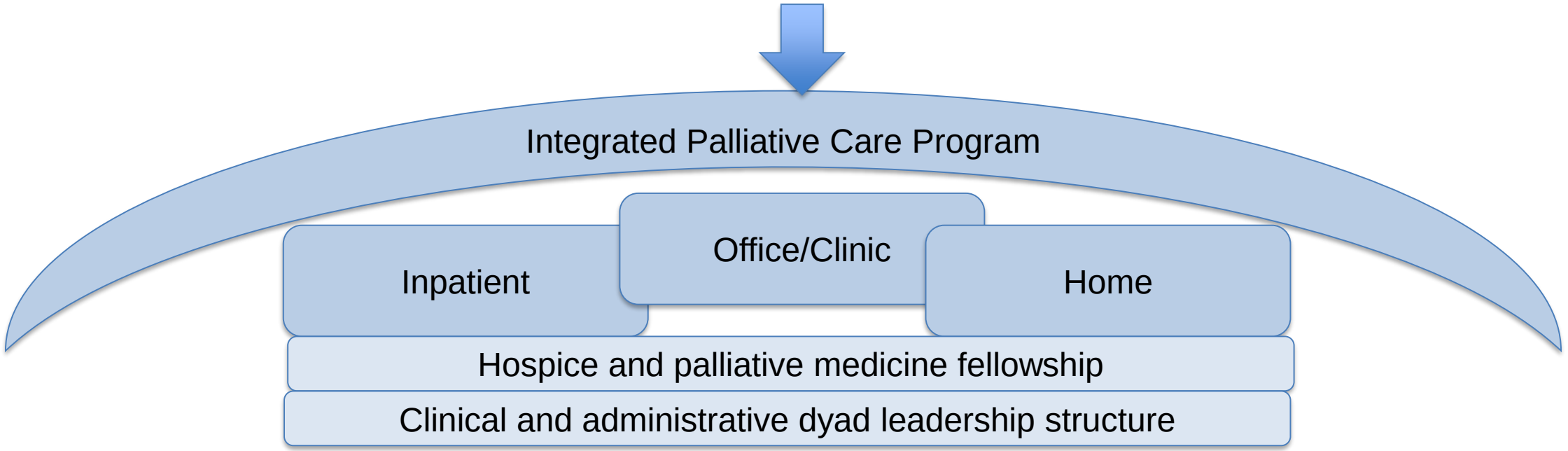
Capitalize on team members' strengths and passions	• Right team member at the right time with the right patient
Transparency	• Create safe space for team members to ask for help and offer help in high or low volume periods
Resiliency/Support	• Take time for team and individual health • Be conscious of burnout and stress in peak periods

Case Example:
Lehigh Valley Health Network

Lehigh Valley Health Network OACIS/Palliative Medicine

Programmatic design via Needs Assessment in 2006

A vehicle for network culture change.
Strategic integration and growth support patients with serious illness within our network.



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Budgeting Considerations

- MD and CRNP Benchmarks are inpatient, but we use them for both inpatient and outpatient
- 2018 AMGA, MGMA, SCA wRVU benchmark weighted avg:
  - **MD** median = 2248, 65th = 2549
  - **CRNP** median = 1894, 65th = 2177
- Used to be median, now budget at 65th-90th percentile wRVU's
- New staff budgeted at 85% of median
- No SW or LPC billing

Budgeting Considerations (cont'd)

- Visits/revenue based on historical billing not benchmarks
- All wRVU targets are budgeted per individual provider, but we are held accountable as roll-up
- Home-based CRNP's are between 65th and 90th percentile of inpatient benchmarks
- CAPC Impact Calculators for inpatient and outpatient used when accounting for deficit
- Hospital benefits from inpatient financial impact, insurance companies benefit from outpatient financial impact

LVHN Inpatient Palliative Medicine Team

Inpatient partnership with hospitalists and sub-specialists
Consult service with 4 MD's, 4 CRNP's, 1 LCSW, 1 LPC, 1 RN, chaplain
Covering 2 hospitals + Tele to outlying site
3,000 consults/year
50-90th percentile wRVU generation
Inpatient revenue covers 50% of total cost

Inpatient LVHN Guiding Principles to Manage Workload

- MD or CRNP + LCSW/LPC/Chaplain/RN = clinical team
- MD/CRNP see all consults due to culture of provider billing and clinical partnership
- Triage consults to identify professional expertise needs
- Schedule based on historical volume
- RN monitors day-to-day volume of each hospital for resource needs
- Keep people whole!
- Build in connections during the day
- Maintain IDT schedule

Inpatient Guiding Principles for High-Volume Days (M-F)

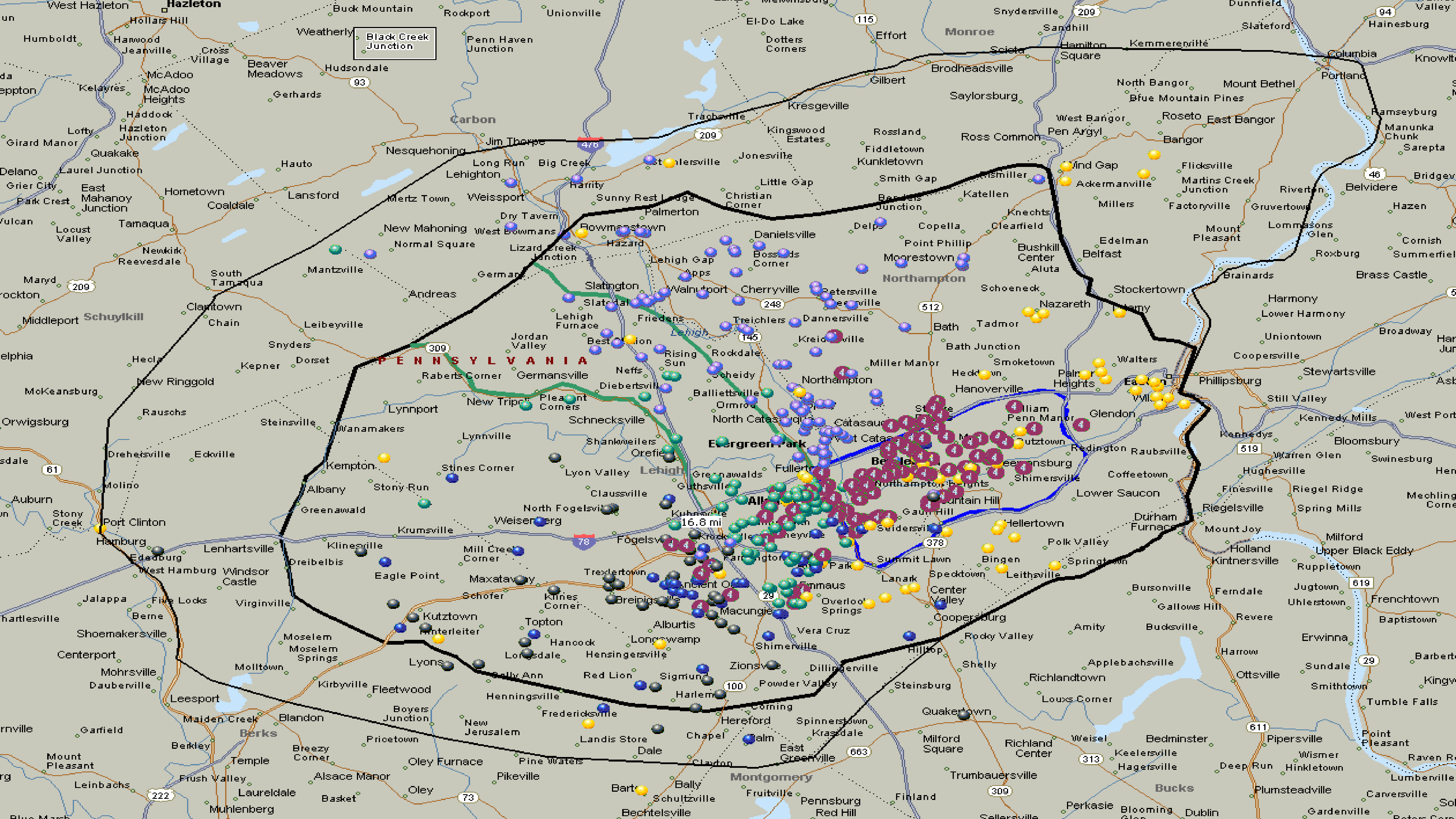
- Triage of follow-up visits--and on rare occasion initial consult--may be done by LCSW/LPC/Chaplain/RN depending on clinical needs
- Cut-off time or max number of consults set
- Some may be left for the following day, preferably not Fridays

Inpatient Guiding Principles for High Volume Weekend Coverage

- Ongoing schedule includes limited staffing that covers both weekend days and two sites
- Triage acuity of consults to assess urgency
- Set max hours or consults per day
- Only go to one site/day

LVHN Outpatient OACIS Team

Home-Based practice + Office-Based practices (growing)
Partnership with PCP's and sub-specialists
Co-management consult service with 7 CRNP's, 1 LCSW, 2 RN's, 2 MA's
Covering 750 square miles
1800 unique patients/year
75-90th percentile wRVU generation
Outpatient revenue covers 60% of total cost


Black Creek Junction
Hazleton
West Hazleton
Buck Mountain
Rockport
Unionville
Weatherly
Penn Haven Junction
Hudsondale
Beaver Meadows
Carbon
Monroe
Northampton
Schuylkill
Berks
Montgomery
Bucks
P E N N S Y L V A N I A
Jim Thorpe
Nesquehoning
Lehighton
Palmerton
Bowmanstown
Slatington
Walnutport
Cherryville
Danielsville
Moorestown
Nazareth
Bath
Northampton
Catasauqua
North Catasauqua
Evergreen Park
Fullerton
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Lynnport
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Stroudsburg
Brodheadsville
Saylorsburg
Kresgeville
Effort
Portland
Columbia
Belvidere
Riegelsville
Milford
Frenchtown
Polk Valley
Lower Saucon
Springtown
Leithsville
Durham Furnace
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663
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309
611
619
519
46
94
61
93
115

Case Study: Home-Based Practice

- Census target of 100 per CRNP; cap of 125 per CRNP
- RN's partner with 3 CRNP's to manage population
- MA's support home-based and office
- Map/regions contract and expand with network need and staffing
- Each CRNP has designated region, co-managed with another CRNP
- Coordinate time off with partner
- Primary focus preventive, minimal urgent visits

Outpatient Guiding Principles for Managing Home-Based Volume

- If CRNP is out, RN's triage scheduled visits to assess acute needs
- Alternate CRNP is consulted, makes visit if possible
- RN reschedules visits

Outpatient Guiding Principles for Managing Home-Based Volume

- Social Worker
  - Consultant to the CRNP's
  - Case management/brief counseling
  - Connects with all other social workers in the network to assure one plan of care and obtain supports
  - When absent, clinical support staff triages needs and forwards to other network social workers

Case Study: Integrated Office Practice

- Organizational Home: Physician Group
- Major stakeholders: Sub-specialist
- Consultative/Co-management role
- Population
- Regionalization
- Focus/scheduling of visits
- Use of support staff
- Scheduling challenges

Outpatient Guiding Principles for Office-Based Practice Developing Volume

Needs Assessment is the roadmap

Stakeholder goals guide the mission

Seek support and guidance from partners

Collaborate with partners on metrics, present dashboard regularly to demonstrate progress

Back-up clinical site for slow am or pm slots

MA functions as quarterback to manage multiple sites

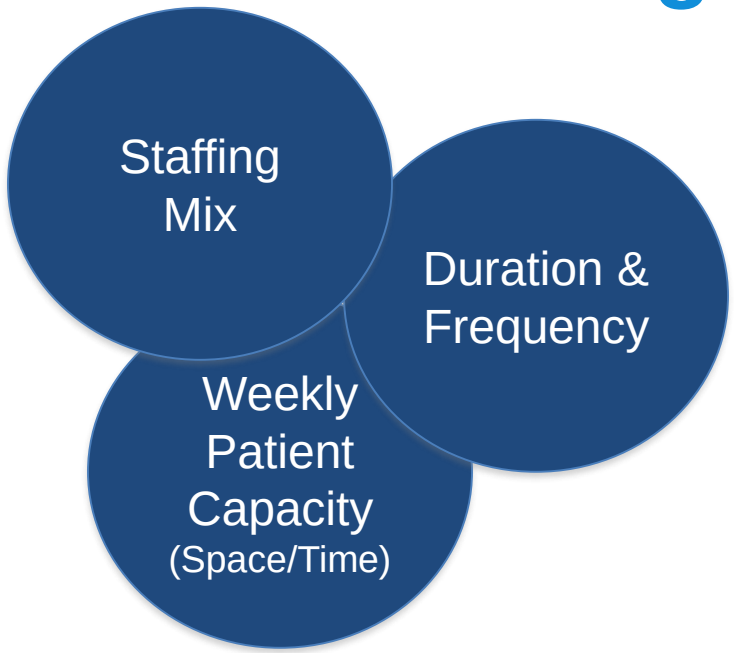
Managing Barriers

- Revisiting Needs Assessment
- Re-aligning goals with stakeholders
- Open dialogue with the team regarding changing priorities
- Allow for non-billable time

The Math

Example Staffing and Workload Modeling Tool for Team-based Staffing

Examples of Trade-offs and Variables That Will Impact Your Staffing and Workload Plans



Example A:

In a co-management vs. consult only model:

- Likely more visits for a longer duration
- Expect fewer new consults due to capacity being used in co-management follow up visits

Example B:

Patient vs. provider convenience

- Narrow geographic coverage maximizes staff time but may not be as easily integrated into more patient's overall care
- Consider creative solutions such as 1st visit in person followed by telephone follow up

TEAM Staffing and Workload Model

Staffing Mix	**Scenario 1** Lower follow up frequency	**Scenario 2** Moderate follow up frequency	**Scenario 3** Higher follow up frequency
MD	0.5	0.5	0.5
APP	2.0	2.5	3.
SW	1.0	0.5	0.
….			
TOTA			

HOME-BASED EXAMPLE

Volumes	**Scenario 1** Lower follow up frequency	**Scenario 2** Moderate follow up frequency	**Scenario 3** Higher follow up frequency
New	500	400	300
Follow - up	1300	1500	1700
TOTAL	1800	1900	2000

Factors:

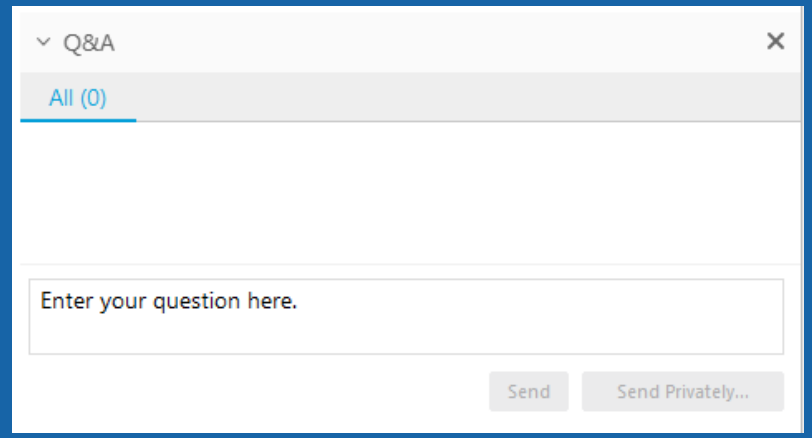
- Drive time
- Documentation time
- New v follow up mix
- Capacity per day
- PTO/CE
- NO SHOWs

Thank you!

Questions and Discussion

How to Submit Questions

Please type your question into the questions pane on your WebEx control panel.



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